DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	All Providers Managed Care Plans Regional Administrators CSO Administrators	**Memorandum No: 01-13 MAA** **Issued:** May 1, 2001 **Supercedes:** 00-06 MAA
From:	James C. Wilson, Assistant Secretary Medical Assistance Administration (MAA)	**For Further Information,** **Call:** 1-800-562-6188

Subject: **Policy Clarification for Billing MAAClients**

The purpose of this memorandum is to familiarize MAA providers with the new Washington Administrative Code (WAC) 388-502-0160, Billing a Client, which became effective August 5, 2000 and was amended March 23, 2001.

This new WAC replaces WAC 388-87-010 and clarifies when a provider may, or may not, bill an MAA client.

Billing Medical Assistance Clients

The general rule is that providers may not bill MAA clients for services covered by MAA.

WAC 388-502-0160(1)(2) states:

> "A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, this chapter, and other chapters regulating the specific type of service provided."
>
> The provider is responsible for verifying whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

First…determine if the patient is an MAA client

Ask the client to bring their Medical Assistance Identification (MAID) card to the appointment. If the client forgets to bring the MAID card, you should check eligibility with available systems (Medical Eligibility Verification or Point of Sale) or, if it is not an emergency situation, you may ask the client to return with the MAID card.

Since eligibility for medical assistance is on a month to month basis, you need to verify eligibility at the time of each visit, and should keep a photocopy of the client's current MAID card. It is important to check the medical program coverage listed on the client's MAID card. A client may be eligible for the full scope of service one month, eligible for a limited scope of service program such as Family Planning the next month, or not eligible at all.

Different MAA programs cover different services

Medical Program Identifier	Program Name	Scope of Medical Benefits
CNP	Categorically Needy Program	Full Scope
CNP – Children's Health	Children's Health	Full Scope
CNP – CHIP	Children's Health Insurance Program	Full Scope
GA-U No Out-of-State Care	General Assistance Unemployable	Limited Scope
General Assistance No Out-of-State Care	Alcoholism & Drug Addition Treatment and Support Act	Limited Scope
LCP-MNP	Limited Casualty Program – Medically Needy Program	Limited Scope
MIP-EMER Hospital Only No Out-of-State Care	Medically Indigent Program	Hospital/ Ambulance Only
QMB-Medicare Only	Qualified Medicare Beneficiary (If Medicare does not cover, MAA does not either.)	Deductibles, Coinsurances

Next…check the Insurance and Medicare Columns on the client's MAID card

Does the client have either private insurance or Medicare? If so, these are the primary payers and must be billed first.

If the client is enrolled in a Healthy Options managed care plan, you may need a referral and/or authorization from the plan to provide care for services covered by the Healthy Options managed care plan; this does not apply to emergency room visits. If the service is not an emergency and you do not have a referral or authorization from the plan, refer the client back to the plan or primary care provider (PCP). This does not apply if the client is seeking a service for which self-referral is permitted under the Healthy Options contract. Healthy OptionsHO clients may self-refer for any of the following:

- Immunizations;
- Family planning services through family planning agencies such as Planned Parenthood;
- Sexually transmitted disease (STD) screening;
- Tuberculosis (TB) testing through the local Health Department; and
- Mental health services through the Regional Support Network (RSN) or community mental health agency.

Check the MAID card to determine if the client is enrolled in the Children's Health Insurance Program (CHIP).

If the client is enrolled in CHIP, the client must pay any appropriate copays directly to the provider, not to MAA. Refer to Numbered Memorandum 99-63 MAA for additional information on CHIP copays. The CHIP identifier is located in the lower right-hand corner of the MAID card above the signature line. The identifier reads "CNP-CHIP."

What if the client doesn't present a MAID card?

You may bill the client if the client:

- Does not present a MAID card; **and**
- States that he/she is a private pay patient; **and**
- Is later found to have been eligible on the date of service <u>not</u> due to delayed eligibility, delayed certification or retro certification; **and**
- Either checks off private pay rather than DSHS or Medical Assistance on the patient's current information and financial responsibility form <u>or</u> signs a statement such as:

  "I am not receiving DSHS medical assistance and I agree to pay for services. If I later become eligible for DSHS medical assistance for the date of this service, I agree to notify the provider's billing office."

  The provider must keep such a signed statement in the client's file.

What if the client wants a noncovered service?

[Refer to WAC 388-502-0160(3)]

You may not bill the client unless, **PRIOR** to receiving any of the following services, the MAA client signs a written agreement to pay for:

- Services that are not within the scope of benefits of the client's MAA medical program;
- Services that the client's plan/PCP/PCCM did not refer for and/or authorize; or
- Services that MAA has determined are not medically necessary.

The agreement must contain all of the following information or the agreement is not valid.

- A statement listing the specific service to be provided;
- A statement that the service is not covered by MAA;
- A statement that the client chooses to receive and pay for the specific service; and
- A statement that the client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements;

If the client is in a managed care program, in addition to all of the requirements listed above, a statement must be included explaining why the client/enrollee is choosing to pay for the service. The reason could be:

- The client/enrollee understands the service is available at no cost from a participating plan provider; or
- The plan has determined that the service is not medically necessary and client/enrollee chooses to pay for the service.

The agreement to pay for noncovered services must be translated or interpreted into the client's primary language and signed before the service is provided. If the agreement is interpreted for the client, the interpreter should also sign and date the agreement to indicate the client understands the agreement.

You must give the client a copy of the agreement to pay for noncovered services and retain the original in the client's file. The agreement must be made available to the department upon request.

☞ **Note:** See Sample of "Informed Consent – Agreement to Pay" on next page.

INFORMED CONSENT

Agreement To Pay

(for a fee-for-service client)

This form must be completed in full <u>before</u> providing a noncovered service or item to a DSHS medical assistance client.

CLIENT NAME:_____ ID NUMBER/PIC:_____

- ✓ I understand that the specific services listed below **<u>are not</u>** covered by my DSHS medical assistance program and are not included as part of another service, or have been determined by DSHS to not be medically necessary.
- ✓ I choose to receive the specific service(s).
- ✓ I agree to pay for the specific service(s).

SPECIFIC SERVICE(S) CLIENT AGREES TO RECEIVE AND PAY FOR:

This agreement is void and unenforceable, and I am under no obligation to pay the provider**, if** my DSHS medical program covers the services listed above or if the provider fails to satisfy DSHS conditions of payment as described under WAC 388-87-010(6).

I understand the purpose of this form and all my questions were answered to my satisfaction.

_____ _____

SIGNATURE OF CLIENT/PARENT/ GUARDIAN/REPRESENTATIVE **DATE**

_____ _____ _____

SIGNATURE OF PROVIDER **PROVIDER NUMBER** **DATE**

***Note to Providers**:* *The services or items listed above **must** be specific in nature.*
Document steps taken to assure that the client fully understands the purpose of this form and that the form has been interpreted and/or translated, as necessary.
For Healthy Options managed care clients, see WAC 388-538-095(5).

Other Permissible Billing Situations

WAC 388-502-0160(3) also allows you to bill a client in any of the following situations:

- The client or the client's legal guardian was reimbursed directly for the service by a third party.

- The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. **This does not apply to medical assistance forms.**

- The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA.

Eligibility Established After Date of Service but Within the Same Month

If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:

- **Not** bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and
- **Promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Retroactive Certification

If, due to retroactive certification,* the client becomes eligible for a covered service that has already been provided, the provider:

- **Must** not bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; and
- **May** refund any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

* **Retroactive Certification** – According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied).

Delayed Certification

If, due to delayed certification,* the client becomes eligible for a covered service that has already been provided, the provider must:

- **Not** bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
- **Promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Buying Up

There are times when an MAA client does not want a covered service or item and wants to "buy up" to a different or more expensive version of the service or item. MAA does not allow clients to "buy up," i.e., pay the difference between what the department pays for the covered item or services and the cost of the non-covered item. In such instances, the client can be held responsible for the entire cost of the service or item.

Examples include:

Wheelchairs: The department covers specific styles and models of durable medical equipment (DME) such as wheel chairs. There are situations when MAA clients choose to "buy up" to obtain a more expensive wheelchair when a less costly wheelchair will meet their needs. In these instances, the entire purchase is a non-covered item and the client may be billed for the total purchase price.

Pharmacy: When a client has been prescribed generic medication and demands the "brand name" medication the client is responsible for the entire cost of the medication.

* **Delayed Certification** – According to WAC 388-500-0005, means department approval of a person's eligibility for a covered service made after the established application processing time limits.

Reminders:

- One of MAA's most common billing complaints is from clients who receive bills from laboratories or radiologists because these ancillary providers did not receive a copy of the MAID card. Please remember that it is the medical provider's responsibility to forward a copy of the MAID card to all ancillary service providers (e.g., radiology, laboratory) when the provider orders these services.

- Another common billing complaint is that pharmacies misinterpret a Point-of-Sale (POS) message as a denial and charge or bill the client instead of calling MAA for prior authorization. Please remember that it is the pharmacist's responsibility to call MAA for prior authorization (PA) when the pharmacist receives a PA message from the POS system. NOTE: If the client is enrolled in a managed care plan, the pharmacist must contact the client's plan for authorization.

Finally, WAC 388-502-0160 also states:

Hospitals may not bill, demand, collect, or accept payment (except for spenddown) from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility.

A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

- Medical charts;
- Radiological or imaging films; and
- Laboratory or other diagnostic test results.

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Change Service Requested